CONTENTS

1. INSTRUCTIONS

To examine and comment upon the statement of Dr Jane Barton re Elsie Devine. In particular, it raises issues that would impact upon any expert witness report prepared.

2. DOCUMENTATION

This report is based on the following document:

2.1 Job Description for Clinical Assistant Post to the Geriatric Division in Gosport as provided to me by the Hampshire Constabulary (February 2005).

2.2 Statement of Dr Jane Barton re Elsie Devine as provided to me by Hampshire Constabulary (February 2005). Appendix 1

2.3 Statement of Dr Jane Barton as provided to me by Hampshire Constabulary (February 2005). Appendix 2

2.4 Report regarding Elsie Devine (BJC/16) Dr D Black 2004.

3. COMMENTS

3.1 Comments on Job Description (2.1)

3.1.1 This confirms the Clinical Assistant is responsible for a maximum of 46 patients and confirms that all patients are under the care of a named Consultant Physician who would take overall responsibility for their medical management. A Clinical Assistant should take part in the weekly consultant ward rounds.

3.1.2 A specific responsibility is the writing up of the original case notes and ensuring the follow up notes are kept up to date and reviewed regularly.

3.1.3 The post is for five sessions a week i.e. is half what a full time doctor would commit to the post. However, the time to be spent in the unit is not specified as the time is allowed to be "worked flexibly".

3.1.4 There appears to be some confusion between the

statements in the job summary, that "patients are slow stream or slow stream for rehabilitation but holiday relief and shared care patients are admitted" and the statement in the previous sentence "to provide 24 hour medical care to the long stay patients in Gosport". The job description appears to be confusing patients for rehabilitation with long stay patients (see discussion paragraph 6.2 of Elsie Devine Report).

3.1.5 There is no comment on the medical cover to be provided when the post holder is unavailable for out of hours or longer period of leave such as holidays. Lack of explicit cover might explain some gaps in the notes.

3.2 Report on the statement of Dr Jane Barton re Elsie Devine (2.2).

The comments refer by page and paragraph to the report. Any numbers in brackets refer to the pages of the photocopies of the notes of Elsie Devine.

3.2.1 Page 1 paragraph 2: Dr Barton again states that Mrs Devine had multiple myeloma. As recorded in my report I believe she did not have multiple myeloma but a separate condition called IgA paraproteinaemia.

3.2.2 Page 1 paragraph 2: States that Mrs Devine had chronic renal failure and nephrotic syndrome. Nephrotic syndrome is a triad of proteinuria, hypoalbuminaemia and oedema, it does not cause chronic renal failure, although, the two may coexist. Page 3 paragraph 1: Dementia is a clinical diagnosis and cannot be "confirmed by CT scan". CT scan is sometimes undertaken to exclude other potential treatable causes that might mimic a clinical syndrome of dementia. Dementia is most commonly caused by Alzheimer's disease. The point of commenting on these two statements is that although they may seem minor misunderstandings, they might also indicate a doctor who did not have a full understanding of the medical conditions that they were managing in a patient with complex medical problems.

3.2.3 Page 3 paragraph 1: Dr Barton states that the CT scan showed "ischaemic changes". The only report that I have been able to find is one that states, "involutional changes only" (24). If the police or other authority can provide further information in relation to this point, I will reconsider my views.

3.2.4 Page 4 paragraph 1: A dose of Oramorphine is prescribed prn. I have been unable to find evidence in the notes that she complained to pain up until that date and the drug charts in

Portsmouth appear to show that she only receive Paracetamol on one occasion on 10th October (269)

Having reviewed page 277 of the photocopies, I agree that the patient was prescribed Oramorphine and not Diamorphine as written in paragraphs 5.19, 6.10, 7.3 or my report and the summary on page 1. This in no way changes or invalidates any of the opinions in my report.

3.2.5 Page 5 paragraphs 1 and 3: These confirm a consultant Dr Reid has seen her on two wards and written appropriate comments in the notes on both 25th October and 1st November. Page 6 paragraphs 2 and 3 confirm that changes in clinical condition did occur from around 9th November and confirm the investigations and management changes could be inferred from the notes. Despite this, nothing is written in the patients' notes until the next consultant ward round on 15th November.

3.2.6 Page 9 paragraph 2: "The hanging on the bars in the main corridor of the ward" has not been recorded in the medical notes (156) and appears to be new and unrecorded clinical information.

3.3 Report on the Statement of Dr Jane Barton as provided to me by the Hampshire Constabulary (2.3):

3.3.1Page 1 paragraph 3: States that she works eight general practice surgery sessions. It is my understanding that most full time General Practitioners work eight or nine sessions. This suggests to me that she is undertaking a full time General Practitioner job and a half time community hospital job. Despite the fact the job description says that the job can be worked flexibly, an opinion should be obtained from an experience General Practitioner as to whether this workload is actually deliverable within a reasonable working week.

3.3.2 Page 1 paragraph 4: The job description states 46 beds, Dr Barton states 48 beds. The CHI report says 44 beds (20 on Dryad and 24 on Daedalus) Dr Barton uses the phrase "continuing care for long stay elderly patients". The job description also referred to slow stream or slow stream rehabilitation as well as holiday relief and shared care patients. There may have been confusion between staff in terms of the objectives of individual patient management (see paragraph 6.2. Devine Report).

3.3.3 Page 1 paragraph 5: This statement is incorrect as the post of Clinical Assistant is not a training post but a service post in the NHS. The only medical training grade posts are pre-registration house officers, senior house officers, specialist

registrars and GP registrars.

3.3.4 Page 1 paragraph 5: States that she and her partners had decided to allocate come of the sessions to "out of hours aspects of the post". This would appear to be a local arrangement of the contractual responsibilities: it needs to be clarified if this was agreed with the Portsmouth and South East Hampshire Health Authority. This would influence how much time was expected to be provided for the patients and influence the pressure on Dr Barton to deliver the aspects of care provided.

3.3.5 Page 2 paragraph 3: This does confirm that there were consultants responsible for all the patients under the care of Dr. Barton. Thus a consultant should always have been available for discussing complex or difficult management decisions. However,(page 3 paragraph 1) , in my view it would be completely unacceptable of the Trust to have left Dr Barton with continuing medical responsibilities for the inpatients of Gosport Hospital without consultant supervision and regular ward rounds. This would be a serious failure of responsibility by the Trust in its governance of patients and in particular failings and in my view the Trust would need to take part of the responsibility for any clinical failings.

3.3.6 Page 3 paragraph 3: This again suggests that Dr Barton was trying to provide her half time responsibilities by fitting the work around her full time responsibilities as a General Practitioner. She suggests 5 patients were admitted each week, implying approximately 250 admissions and discharges a year. With a bed occupancy around 80%, this would suggest an average length of stay of 5 – 6 weeks. However, CHI state the actual figures were somewhat less, 1997/98 were 169 FCE's for Dryad and Daedalus and 197 FCE's in 1998/99. A new patient assessment including history and examination, writing up the notes, drug charts, talking to the nurses, talking to any relatives present and undertaking blood tests if these had to be taken by a doctor rather than any other staff, would take a maximum of 60 minutes.

Page 5 paragraph 2: The patients who were genuinely long stay or continuing care do not need to be reviewed medically every day, nor would a medical record be made daily. Indeed with average length of stay of six or more weeks, it is clear that many patients were genuinely long-stay patients and one would expect them to be medically reviewed no more than once a week and any medical comments to be no more than once a week. However, whenever patients' physical or mental state has changed and they are reviewed by a doctor, it would be normal practice to always make a comment in the notes.

Patients who are in rehabilitation and making a good progress, then review and comments in the notes once or twice a week would also be the norm.

It is my view that with less than 200 FCE's and a total of 44 inpatients, then this should be satisfactorily managed by somebody working half time as a Clinical Assistant with regular consultant supervision.

3.3.7 Page 4 paragraph 2: This suggests that Dr Barton is stating that she takes personal responsibility for most changes in medication, rather than it being a nursing decision.

3.3.8 Page 9 paragraph 2: An individual doctor must take responsibility for their prescribing however I would agree that consultants should also take responsibility for ensuring patients under their care were having appropriate medical management. It does appear that there was a consultant responsible for all patients in both Dryad and Daedalus Ward.

4. CONCLUSION

4.1 Having read all the documents above provided by Hampshire Constabulary, the only change I would wish to make to my export report is in paragraphs 5.19, 6.10, 7.3 in the summary on page 1, the patient was prescribed Oramorphine and not Diamorphine as written in the report.

Devine/ Barton statements Version 5 16 April 2005

APPENDIX 1

Devine/ Barton statements Version 5 16 April 2005

APPENDIX 2